STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365206	a. building _____ b. wing _____	**05/06/2019**

name of provider or supplier	street address, city, state, zip code
UPTOWN WESTERVILLE HEALTHCARE	**140 OLD COUNTY LINE ROAD WESTERVILLE OH, 43081**

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F 0000	INITIAL COMMENTS SPECIAL FOCUS SURVEY PARTIAL EXTENDED SURVEY COMPLAINT INVESTIGATION MASTER COMPLAINT NUMBER OH00104109 and COMPLAINT NUMBER OH00104099, OH00104005 and OH00103991 ADMINISTRATOR: Matthew Dapore, #5096 CERTIFIED BED CAPACITY: 174 CENSUS: 111 MEDICARE: 07 MEDICAID: 58 OTHER: 46 The following deficiencies are based on the complaint investigations and partial extended survey completed on 05/06/19. The facility also remains out of compliance from the surveys dated 04/22/19, 04/09/19, 04/01/19, 03/06/19, 02/04/19, 01/23/19, 01/08/19, 12/13/18 and 11/21/18.	F 0000		

laboratory director's or provider/supplier representative's signature	title	(x6) date
	SARAH.ROSE	05/17/2019

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F 0558	Continued From page 1	F 0558		
F 0558 SS=D	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This STANDARD is not met as evidenced by: Based on observation, medical record review and resident and staff interview, the facility failed to provide one of three sampled residents (Resident #121) with water when requested. The facility census was 111. Findings include: Review of Resident #121's medical record revealed the resident was admitted to the facility on 04/27/17. Diagnoses included hospice services for end of life care, stroke, dysphasia and Parkinson disease. Review of Resident #121's hospice written plan of care, dated 04/11/19, revealed the resident had dysphasia (difficulty swallowing) but would like water to drink. Review of physician orders, dated 03/06/19, revealed the resident was on pleasure foods per resident request, nectar thick water per request. The record identified Resident #121 was receiving comfort care only.	F 0558	On 5/2/19 the STNA provided Resident #121 with ice chips as requested. On 5/2/19 the Nurse Manager assessed Resident #121 for any s/sx of discomfort or fluid volume deficit and no adverse findings were identified. Resident #121 care plan was reviewed by the Nurse Manager to ensure accurate diet orders were accessible to the nursing staff on the Resident Kardex. On 5/2/19 DON or Designee began audit to ensure all Resident's with an altered liquid consistency had an accurate diet order and care plan was reviewed to ensure accurate diet orders were accessible to the nursing staff on the Resident Kardex. On 5/2/19 the DON or Nurse manager assessed all residents receiving altered liquid consistency for s/sx of discomfort or fluid volume deficit and no negative findings were identified. On 5/2/19 DON educated STNA #35 and STNA #750 on the resident Kardex to identify fluid intake order and to immediately consult the nurse if unsure for further direction so there was no delay in meeting the Residents needs. The DON or designee will educate facility STNA and licensed nursing staff on Resident Rights (reasonable accommodations of needs/preferences) where to identify the Residents current diet/fluid intake order and immediate actions to ensure there is no delay in meeting Residents needs by 5/10/19. The DON or designee will conduct random audits of 3-5 resident medical records to	05/10/2019

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F 0558	Continued From page 2 Observation of Resident #121, receiving care from State Tested Nursing Assistants (STNA) #35 and #750, was completed on 05/02/19 at 9:12 A.M. Resident #121 was observed asking STNA #35 for a drink multiple times while was receiving care. STNA #35 was heard telling Resident #121 "I don't think your allowed to have anything". Interview with Resident #121 on 05/12/19 at 12:11 P.M. revealed Resident #121 confirmed he wanted a drink and never received one after asking this morning. Interviews with STNAs #35 and #750 on 05/12/19 at 12:15 P.M. confirmed they did try and look up if Resident #121 could have a drink and could not find anything and therefore did not provide him with anything. STNA #35 identified she would go ask Licensed Practical Nurse (LPN) #50 at this time. STNA #35 returned and identified LPN #50 told her she could give him ice chips only. This is an incidental finding during the course of the complaint investigation.	F 0558	ensure accuracy and interview those resident's to ensure they are receiving fluids per their preference/request 3 x weekly x 4 weeks, then as determined by the QAA committee.	

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F 0580	Continued From page 3	F 0580		
F 0580 SS=D	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate	F 0580	Resident #4 no longer resides in the facility and currently resides in another SNF. On 4/17/19 at 23:04 Resident #4 PT/INR results were reported to Med One with no new orders. On 4/18/19 at 00:52 Resident #4 was sent to the ER per order for evaluation and treatment. On 5/3/19 DON and Nurse manager assessed all Residents on coumadin therapy for any change in condition and no adverse findings were identified. On 5/09/19 DON and nurse manager began medical record review audit to identify any documented change in condition and all residents current coumadin therapy regimen was reviewed with the Resident's physician or CNP by 5/10/19. No further adverse outcomes were identified related to coumadin therapy. On 5/3/19 DON and Nurse Managers re-educated licensed nursing staff on Physician Notification Policy(which includes critical lab value notification), Change in Condition Policy, 10 Rights of Medication Administration and S/Sx and risks associated with a non-therapeutic PT/INR and factors that may effect INR levels. On 5/3/19 the DON and Nurse Managers re-educated STNA staff on S/Sx of abnormal bleeding and Change in Condition Policy. Don or designee will audit the medical record of resident's receiving coumadin 2x weekly x 4 weeks to ensure MAR is accurate per physician order, laboratory draws are accurate and therapeutic, Lab values are addressed with	05/10/2019

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F 0580	Continued From page 4 assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure notification to the physician of a significant change in condition for one resident (Resident #4). This affected one of three residents reviewed for a significant change. The facility census was 111. Findings include: Review of Resident #4's medical record	F 0580	the physician/CNP , identify change in condition with appropriate physician/CNP notification and ensure Resident is negative for any S/Sx of abnormal bleeding. Need for further auditing will be determined by the QAA committee.	

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F 0580	Continued From page 5 revealed the resident was admitted to the facility on 6/27/18. Diagnoses included atrial fibrillation, history of deep vein thrombosis and peripheral vascular disease. Review of the comprehensive assessment, dated 04/02/19, revealed Resident #4 was alert, oriented and able to voice all needs. The assessment identified Resident #4 had two venous/arterial ulcers. Review of the April 2019 physician orders identified Resident #4 was receiving Coumadin daily for atrial fibrillation. Review of Resident #4's progress note, dated 04/15/19 at 7:07 P.M., revealed the laboratory results received for the resident's prothrombin time (PT), which is used to monitor blood thinning medications, was at a level of 52.2 seconds; (normal range 9.5-11.8 seconds) and an INR at 4.7 with normal range (2.0-3.0 standard anti-coagulant). The noted identified the physician was notified and ordered the medication Coumadin held and recheck the PT/INR tomorrow (04/16/19). The laboratory findings identified the INR levels as critical. The progress note, dated 04/15/19 at 10:53 P.M., identified the Certified Nurse Practitioner (CNP) ordered Levaquin (antibiotic medication) for a urinary tract infection (UTI). The CNP additionally ordered INR testing every other day, for a week.	F 0580		

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F 0580	Continued From page 6 The progress note, dated 04/16/19 at 5:26 P.M., revealed the results of the PT/INR were received, and the on-call physician was notified. The PT was 55.5 and INR was 5.0 and the physician ordered a hold on the Coumadin medication. The notes additionally identified to retest tomorrow. The laboratory findings identified the INR levels were critical. The progress note, dated 04/17/19 at 5:20 A.M., revealed at 4:00 A.M., there was a significant amount of bright red blood saturating the entire left lower extremity dressing and sheet of Resident #4. There was no evidence the physician was notified of the significant event. Interview on 05/02/19 at 2:20 P.M. with the Director of Nursing (DON) confirmed Resident #4 had "significant bleeding" on 04/17/19 at 5:20 A.M. and there was no evidence the physician was notified. This is an incidental finding discovered during the complaint investigation. This is an example of continued non-compliance from the survey dated 12/13/19.	F 0580		

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F 0600	Continued From page 7	F 0600		
F 0600 SS=J	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This STANDARD is not met as evidenced by: Based on review of the medical record, emergency medical report, law enforcement report, facility abuse policy, interviews with the staff, family and local police and jail staff, the facility failed to ensure Resident #2 was free from neglect. This resulted in Immediate Jeopardy when Resident #2 was refused readmittance to the facility without being provided a 30 day discharge notice. This posed the likelihood of imminent danger or harm when Resident #2 was turned away from the facility after arriving by public transportation with no plan for a discharge location, medications to treat the multiple medical conditions and necessary services	F 0600	Resident #2 was admitted to the hospital on 4/25/19. Resident #2 was readmitted to facility on 5/9/19 and transferred to OSU Medical Center on 5/10/19. DON/Designee will identify all residents with the potential to discharge to the community. All resident's care plans will be reviewed and revised as needed for safe discharge planning by 5/2/19. DON/Designee will review all resident's discharged from the facility in the past 30 days to ensure the resident received a safe discharge by 5/2/19. Administrator/Designee educated all facility staff on Abuse Prevention Policy and Procedure, Identifying Signs and Symptoms of Abuse, Abuse Reporting, and Re-Admission Process on 5/3/19. No staff were permitted to return to work unless they had been educated. Administrator/Designee will audit all resident discharges prior to discharge to ensure safe discharge plans x 4 weeks, then as determined by the QAA committee.	05/10/2019

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F 0600	Continued From page 8 to meet the resident's care needs. This affected one of three residents reviewed for proper discharge. On 05/02/19 at 1:12 P.M., the Administrator and Regional Director #42 were notified Immediate Jeopardy began on 04/25/19 when Resident #2 called police to the facility because he was refused water. Resident #2 had an outstanding warrant and spent the night in jail. He was refused readmittance to the facility following the overnight stay at the jail. Resident #2 was turned away from the facility without any personal belongings or medical needs and was found by local police at 9:30 P.M. walking in the middle of a road near the facility. He was transported by emergency medical services (EMS) to the local hospital where he was admitted. The Immediate Jeopardy was removed on 05/03/19 at 1:30 P.M. when the facility implemented the following corrective actions: • Resident #2 was admitted to the hospital on 04/25/19. Resident #2 is scheduled to be readmitted to the facility after a 14-day hospitalization at a behavioral hospital. • On 05/02/19, the Director of Nursing (DON) will identify all residents with the potential to be discharge to the	F 0600		

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F 0600	Continued From page 9 community. All resident's care plans will be reviewed and revised as needed for safe discharge planning by end of day, 05/02/19. • On 05/02/19, the DON/Designee will review all residents discharged from the facility in the past 30 days to ensure the residents received a safe discharge to the community. All resident's care plans will be reviewed and revised as needed for safe discharge planning, by end of day 05/02/19. • On 05/02/19, the Administrator/Designee will educate all facility staff on Abuse/Neglect Prevention Policy and Procedure, Reporting all allegations of abuse and the Re-Admission policy and procedure. As of 05/03/19 11:15 A.M. education was not completed. On 05/03/19 at 1:30 P.M., all staff education was completed. • On 05/02/19, the Administrator/Designee will audit all resident discharges before discharge to ensure safe discharge plans by four weeks, then as determined by the Quality Assurance and Assessment Committee. • On 05/02/19, surveyors reviewed three additional resident records (Resident #27, Resident #71 and Resident #121) for residents who were residing in the facility. The reviews revealed there were no signs	F 0600		

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F 0600	Continued From page 10 of neglect. Interviews and observations with these three residents revealed no concerns involving neglect. • On 05/03/19 from 10:40 A.M. to 11:15 A.M., interviews with Licensed Practical Nurse (LPN) #160, #162 and #164, Housekeeper #12 and #124 revealed they have not been in-serviced on abuse. They received abuse handouts and plan to read them that day. Environmental Services Director #72 and State Tested Nursing Aide #126 verified they received training on abuse on 05/02/19. On 05/03/19 at 1:30 P.M., LPN #160, #162 and #164, Housekeeper #12 and #124 had been trained on abuse. Although the Immediate Jeopardy was removed, the facility remained out of compliance at a Severity Level 2 (No actual harm with potential for minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan to ensure ongoing compliance. Findings include: Review of Resident #2's closed medical record revealed an admission date of 01/08/17 with diagnoses including chronic kidney disease Stage IV, syncope and collapse, type II diabetes, bipolar disorder, hyperlipidemia, major depressive disorder, osteoarthritis, unspecified mood disorder,	F 0600		

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F 0600	Continued From page 11 chronic pain, peripheral vascular disease, Parkinson's disease, unspecified kidney failure, unspecified abdominal pain, weakness, cognitive communication deficit and difficulty walking. Review of physician orders revealed the following were some of the daily medications Resident #2 required to treat medical diagnoses: • Depakote Delayed release 250 milligrams (mg) every six hours; seizure and manic episode treatment • Lipitor 10 mg once daily; treatment of hyperlipidemia • Amlodipine Besylate 5 mg daily; treatment of hypertension • Actos 15 mg daily; treatment of diabetes • Invega Extended release 3 mg daily; treatment of mood disorder • Tamulosin HCl 0.4 mg; treatment of prostate hyperplasia • Oxybutynin Chloride 5 mg twice daily; treatment of painful urination/frequency • Trihexyphenidyl HCl 2 mg twice daily; treatment of Parkinson ' s Disease	F 0600		

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F 0600	Continued From page 12 • Gabapentin 200 mg three times daily; treatment of nerve pain • Accu-check every morning to check blood sugars and notify physician if over 400 or under 40 milligrams per deciliter (mg/dl). Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment, dated 03/25/19, revealed Resident #2 was cognitively intact and required supervision and physical assistance for bed mobility, transfers, walking in corridor, walking in room, and locomotion on unit. He required total dependence for bathing, extensive physical assistance for personal hygiene, limited physical assistance with toilet use and dressing, and only supervision with eating and locomotion off unit. Review of admission documentation revealed Resident #2 was his own responsible party and his son was listed as an emergency contact. Review of progress notes from 01/01/19 through 04/11/19 revealed Resident #2 had no documented behaviors. Review of progress notes from 04/12/19 to 04/23/19 revealed 15 entries related to verbal aggression from Resident #2 to staff and other residents. Resident #2 was taken to the emergency room on 04/18/19 to be assessed for his mental health. He returned to the facility the same day due to	F 0600		

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F 0600	Continued From page 13 not meeting the threshold to be admitted to a psychiatric unit. The facility had contacted local law enforcement on 04/19/19 related to documentation that Resident #2 was aggressive and refused to go to the hospital for evaluation, but the police officers declined to transport the resident as he did not meet the criteria. Resident #2 remained at the facility at that time. Review of the facility's Self-Reported Incidents to the State Agency revealed no evidence of any incidents in the previous 30 days involving Resident #2. Review of a progress note dated 04/23/19 by Licensed Practical Nurse (LPN) #1 documented Resident #2 asked for ice water and when the aide on the hall went to give it to him, he called an aide a black slave (expletive), stating he did not want it from him or the (expletive) nurse. Resident #2 was noted to be in the hall yelling at staff and slamming his walker down. Resident #2 retreated to his room and called the police to complain about his care. The local police arrived and spoke with staff and Resident #2. The police ran Resident #2's name through their system and located two outstanding warrants unrelated to the facility stay. Resident #2 was handcuffed and removed from the facility and taken to the local police station. On 04/23/19, an MDS assessment was started but not completed for Resident #2 regarding "Discharge, return not anticipated."	F 0600		

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F 0600	Continued From page 14 Review of the medical record revealed Resident #2 was discharged on 04/23/19. There was no documentation in the medical record regarding any specifics or details of the resident's discharge from the facility including transfer location, education on his medical care or physician follow up appointment or retrieving/obtaining current prescribed medications. Review of the law enforcement report number 19-10814, dated 04/23/19, revealed law enforcement arrived at the nursing facility due to Resident #2 calling and stating the nursing staff would not provide him water. While in the facility, they determined Resident #2 had two outstanding warrants related to non-compliance with a protection order. He was placed in handcuffs and removed from the facility and taken to the county jail. Review of the law enforcement report number 19-11044, dated 04/25/19 between 9:25 P.M. and 10:11 P.M., revealed Resident #2 was observed walking in the middle of the road. Police were dispatched to his location on the same road as the facility. When police arrived, they attempted to call the facility, but received no answer. They attempted again and spoke with a facility nurse who stated Resident #2 was "banned" from the facility.	F 0600		

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UPTOWN WESTERVILLE HEALTHCARE	**140 OLD COUNTY LINE ROAD WESTERVILLE OH, 43081**

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F 0600	Continued From page 15 At that time, police contacted EMS because they felt Resident #2 was having a "diabetic emergency". There was no other documentation relayed to a diabetic emergency. When EMS arrived, they assessed him and took him to the emergency facility. Review of EMS run report number 2019-00002586, dated 04/25/19, revealed Resident #2 had no injuries, and there were no complaints from the resident. The report indicated EMS met with patient and police officer. Patient stated he was trying to get back home and he was no longer welcomed in the nursing facility. Police officer reiterated the same thing when he asked the facility about Resident #2 entering the nursing facility. EMS spoke with the facility nurse and nurse stated, "he had been discharged by the facility and insurance would not pay for stay." At that time, Resident #2 was taken to the emergency room. Review of the emergency room's history and physical, dated 04/26/19, revealed the resident was going to receive care for encephalopathy (a brain disease that alters brain function or structure), which was noted most likely secondary to schizoaffective exacerbation and to receive care for acute onset chronic kidney disease. Interview with Hospital Staff #19 on	F 0600		

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F 0600	Continued From page 16 04/29/19 at 11:52 A.M. revealed Resident #2 arrived at the medical facility on 04/25/19 at about 10:15 P.M. She stated he was not acting out of the ordinary or to the point that she felt he needed a psychiatric hold. Hospital Staff #19 helped him into an emergency room holding room, where Resident #2 remained the rest of the night. The next day (04/26/19) at approximately 2:30 P.M., Hospital Staff #19 contacted the nursing facility to find out if Resident #2 could return. She talked to Social Service Assistant (SSA) #92 and Former Director of Nursing (DON) #7 at the facility, who stated they spoke with Former Administrator #48, and they would not allow Resident #2 back into the facility. They told her that he was potentially violent, staff was afraid of him, and he would not be returning. At that time, Hospital Staff #19 worked to find a place for the resident to go. Resident #2 did not meet the criteria for a psychiatric hospital, so he was admitted to a hospital that had a psychiatrist who did floor rounds. Resident #2 was sent to this hospital on 04/26/19 and (to her knowledge), remained there to this day. Interview with Police Dispatcher #23 on 04/29/19 at 12:19 P.M. revealed the police were dispatched to the road the facility was located on by a concerned citizen on 04/25/19. They found Resident #2 in the middle of the road, so they picked him up. Resident #2 stated he was at the nursing	F 0600		

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F 0600	Continued From page 17 facility until the day before (04/23/19), but he was told when he arrived back (on 04/25/19) that he had been discharged and not allowed to return. The police officer attempted to contact the facility, but no one answered. He finally got a hold of a nurse, and the nurse stated Resident #2 was banned from the facility. At that time, police called EMS and they took him to the emergency room for assessment. Interview with Resident #2's family member on 04/29/19 at 1:44 P.M. revealed he was never told that Resident #2 was discharged from the nursing facility. Hospital Staff #19 called him and told him what happened, regarding the arrest and being taken to the emergency room. He stated he received a call from the facility on 04/26/19 and was told initially that Resident #2 could not be readmitted. But later that day, he received a call from Admissions Director #201 who stated Resident #2 could come back. He was also contacted on 04/29/19 by Admissions Director #201 and asked where Resident #2 was located. He did not tell them because he wasn't sure what they would have him sign. They stated again that he was welcome to come back to the facility. He stated he does not feel comfortable going to the facility to get Resident #2's personal belongings, so he was not sure what he was going to do. Interview with the Administrator on 04/29/19 at 11:35 A.M. and 12:09 P.M.	F 0600		

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F 0600	Continued From page 18 confirmed Resident #2 did not receive adequate discharge information (list of medications, doctor's information, supply of medications, etc.) when he was discharged following his arrest on 04/23/19. He also confirmed that Resident #2's family was not notified by the facility about his discharge in a timely manner. He confirmed there was no bed hold notification, no discharge documentation or report given to the resident/family or to the arresting officers when he left. At the time of this interview, he did not know Resident #2 attempted to return to the facility and was banned from entering/being readmitted. He thought Resident #2 was still in jail at the time of this interview. Interview with SSA #92 on 04/29/19 at 12:30 P.M. revealed Resident #2 was discharged from the facility because he called the police, they arrived at the facility, they "ran his name," and found that he had violated his restraining order and then he was arrested. To her knowledge, he never returned to the facility to ask if he could be readmitted. SSA #92 stated on 04/26/19 at approximately 2:30 P.M., a social worker from a medical facility/emergency room called and stated Resident #2 was in the emergency room and wanted to know "what was going on with him." She also wanted to know if he could go back to the facility. SSA #92 stated she spoke with the Former Administrator who said, "We are not taking	F 0600		

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F 0600	Continued From page 19	F 0600		

him back for any reason." SSA #92 had to relay this message to the hospital social worker. To SSA #92 ' s knowledge, no one was notified of Resident #2's discharge, including his son. SSA #92 confirmed she did not set up home health or any other type of medical assistance when Resident #2 was discharged from the facility on 04/23/19.

An attempt was made to interview Resident #2 on 04/29/19 at 1:51 P.M. and 4:07 P.M., and 04/30/19 at 10:25 A.M. but attempts were unsuccessful.

Attempts to interview LPN #100, the nurse who stated Resident #2 was banned from the facility, on 04/29/19 at 1:10 P.M. and 04/30/19 at 9:05 A.M. were unsuccessful.

Telephone interview with the Former Administrator on 05/01/19 at 1:07 P.M. revealed she was not notified Resident #2's attempted return to the facility on 04/25/19. She stated that no staff tried to call her the night of 04/25/19. She said the interdisciplinary team discussed Resident #2 returning to the facility on 04/26/19 during the morning meeting. She stated the corporate consulting nurse (Current DON) in the meeting stated to not allow Resident #2 to return to the facility.

Interview with the DON on 05/02/19 at 12:02 P.M. revealed she was not notified by any facility staff on 04/25/19 regarding

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F 0600	Continued From page 20 Resident #2. The DON stated the Former Administrator and Former DON made the decision to not allow Resident #2 back into the facility. Review of facility "Emergency Transfer/Discharge" policy, dated April 2017, revealed the facility attempts to meet the needs of residents within the facility, but in an acute situation when it is not in the best interest of the resident due to medical or safety reasons, an emergency transfer or discharge is implemented. Should it become necessary to implement an emergency transfer or a 30-day discharge to a hospital or other facility, the following procedures will be completed: notify the resident's physician, may be done after transfer in an emergency; notify the receiving facility the transfer is being made and provide relevant information, arrange transportation if not arranged by the receiving facility; prepare the resident for transfer, prepare transfer form, medication lists, code status, and other relevant documentation to send with the resident. Review of the facility's abuse/neglect prevention policy and procedure, dated 01/01/16, revealed the facility will follow state and federal guidelines on preventing abuse, neglect, mistreatment, exploitation and misappropriation of property. Neglect was defined as the failure to provide goods and services necessary to avoid physical	F 0600		

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F 0600	Continued From page 21 harm, mental anguish, and mental illness. The training part of the procedure included to train all new employees on resident rights and how residents are to be treated and what to do if the employee suspects that the resident's rights have been violated and when and how to report witnessed, alleged or suspected abuse. This deficiency substantiates Complaint Number OH00103991. This deficiency is an example of continued non-compliance from the survey dated 04/22/19.	F 0600		

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F 0607	Continued From page 22	F 0607		
F 0607 SS=F	483.12(b)(1)-(3) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This STANDARD is not met as evidenced by: Based on review of employee personnel records, review of the Bureau of Criminal Identification and Investigation (BCI & I)log, review of the Ohio Attorney General's website, review of the abuse policy and procedures and staff interviews, the facility failed to follow their policies to obtain and submit employee fingerprints to the BCI & I. The facility identified 36 employees hired since 12/21/18 that did not have finger prints submitted to the BCI & I Registered Nurse (RN) #11, #13, #20, #22, #24 and #35; Licensed Practical Nurse (LPN) #3, #7, #8, #10, #12, #14, #15, #16, #17, #19, #21, #25, #26, #27 and #32; State Tested Nursing Assistants (STNA) #1, #4, #29, #30, #31, #34 and #36; Kitchen staff (#2	F 0607	finger prints were submitted to the BCI & I for Registered Nurse (RN) #11, #13, #20, #22, #24 and #35; Licensed Practical Nurse (LPN) #3, #7, #8, #10, #12, #14, #15, #16, #17, #19, #21, #25, #26, #27 and #32; State Tested Nursing Assistants (STNA) #1, #4, #29, #30, #31, #34 and #36; Kitchen staff (#2 and #6); Activities staff (Activities #9); Receptionist #18; Housekeeping staff (Housekeeping #5 and #28); Licensed Social Worker (LSW) #23; and Admissions Staff #33) by 5/3/2019. On 5/3/2019 the Administrator/designee reviewed resident concern forms and resident council minutes for the past 30 days to ensure all concerns were addressed and no residents had adverse outcomes related to the fingerprinting. No adverse findings were identified. On 5/2/19 DON/Designee re-educated all staff on the abuse policy and were unable to return to work until the education was received. On 5/16/19 the Background Check Policy was revised by the VP of Clinical Services. Regional Director of Clinical Services educated the Administrator, HR Director, and Department Managers on the revised Background Check Policy on 5/17/19. Administrator/Designee will audit all new employee files for evidence of compliance with the Background Check Policy and finger printing prior to the employee beginning work x 4weeks, then as determined by the QAA	05/17/2019

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F 0607	Continued From page 23 and #6); Activities staff (Activities #9); Receptionist #18; Housekeeping staff (Housekeeping #5 and #28); Licensed Social Worker (LSW) #23; and Admissions Staff #33). This had the potential to affect all 111 residents residing in the facility. Finding include: Review of the BCI&I log and interview with the facility Administrator on 05/01/19 at 9:17 A.M. revealed a new corporation took ownership of the facility on 12/21/18. The Administrator verified 36 employees have been hired since that time who are still employed at the facility. The Administrator verified none of the 36 employees: (RN) #11, #13, #20, #22, #24 and #35; Licensed Practical Nurse (LPN) #3, #7, #8, #10, #12, #14, #15, #16, #17, #19, #21, #25, #26, #27 and #32; State Tested Nursing Assistants (STNA) #1, #4, #29, #30, #31, #34 and #36; Kitchen staff (#2 and #6); Activities staff (Activities #9); Receptionist #18; Housekeeping staff (Housekeeping #5 and #28); Licensed Social Worker (LSW) #23; and Admissions Staff #33) have had a set of finger prints completed and submitted to BCI&I for a criminal records check to be completed. The Administrator verified the facility was utilizing a company identified as "Ohio Background Check, INC" that completes a background check but does not utilize fingerprints. The facility was unable to provide any evidence	F 0607	committee.	

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F 0607	Continued From page 24 of what this company was utilizing to complete the "background checks". Review of the Ohio Attorneys General web-site (ohioattorneygeneral.gov) revealed BCI&I compares fingerprints received against database of criminal fingerprints to determine if there is a criminal record. The site identified all fingerprints must be submitted to BCI&I electronically through a webcheck or a scan card. Review of the facility "abuse, abuse prevention" policy and procedure dated 01/01/16 identified in the section for screening staff included; "criminal background checks are conducted per this facility's policy and procedure. Potential employees or volunteers with negative findings of background checks will not be hired". Review of the "employee background checks" policy dated 10/2018 identified "all employees will conduct a background check through the BCI&I prior to starting work." This policy also incorrectly identified staff would be able to start work and work for 90 days until the results of the check are returned. This deficiency was cited as an incidental finding to Master Complaint Number OH00104005 and Complaint Number OH00103991.	F 0607		

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F 0607	Continued From page 25 This deficency is an example of continued non-compliance from the survey dated 04/22/19.	F 0607		
F 0609 SS=D	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if	F 0609	Resident #2 was admitted to the hospital on 4/25/19. Resident #2 was readmitted to facility on 5/9/19 and transferred to OSU Medical Center on 5/10/19. Resident #3 no longer resides in the facility. DON/Designee will identify all residents with the potential to discharge to the community. All resident's care plans will be reviewed and revised as needed for safe discharge planning by 5/2/19. DON/Designee will review all resident's discharged from the facility in the past 30 days to ensure the resident received a safe discharge by 5/2/19. Administrator/Designee educated all facility staff on Abuse Prevention Policy and Procedure, Identifying Signs and Symptoms of Abuse, Abuse Reporting, and Re-Admission Process on 5/3/19. No staff were permitted to return to work unless they had been educated. Administrator/Designee will audit all resident discharges prior to discharge to ensure safe discharge plans x 4 weeks, then as determined by the QAA committee.	05/10/2019

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F 0609	Continued From page 26 the alleged violation is verified appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on review of the medical record, emergency medical report, law enforcement report, facility abuse policy, interviews with the staff, family and local police and jail staff, the facility failed to investigate and report an incident of suspected neglect to the State Agency for two residents (Resident #2 and Resident #3). Resident #2 was discharged from the facility without necessary care and services to avoid physical harm or mental anguish and Resident #3 was not permitted to return to the facility following an overnight hospital stay. This affected two of three residents reviewed for proper discharge. Findings include: Review of Resident #2's closed medical record revealed an admission date of 01/08/17 with diagnoses including chronic kidney disease Stage IV, syncope and collapse, type II diabetes, bipolar disorder, hyperlipidemia, major depressive disorder, osteoarthritis, unspecified mood disorder, chronic pain, peripheral vascular disease, Parkinson's disease, unspecified kidney failure, unspecified abdominal pain, weakness, cognitive communication deficit and difficulty walking.	F 0609		

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F 0609	Continued From page 27 Review of physician orders revealed the following were included in the daily medications Resident #2 required to treat medical diagnoses: 1. Depakote Delayed release 250 milligrams (mg) every six hours; seizure and manic episode treatment 2. Lipitor 10 mg once daily; treatment of hyperlipidemia 3. Amlodipine Besylate 5 mg daily; treatment of hypertension 4. Actos 15 mg daily; treatment of diabetes 5 Invega Extended release 3 mg daily; treatment of mood disorder 6. Tamulosin HCl 0.4 mg; treatment of prostate hyperplasia 7. Oxybutynin Chloride 5 mg twice daily; treatment of painful urination/frequency 8. Trihexyphenidyl HCl 2 mg twice daily; treatment of Parkinson ' s Disease 9. Gabapentin 200 mg three times daily; treatment of nerve pain 10. Accu-check every morning to check blood sugars and notify physician if over	F 0609		

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F 0609	Continued From page 28 400 or under 40 milligrams per deciliter (mg/dl). Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment, dated 03/25/19, revealed Resident #2 was cognitively intact and required supervision and physical assistance for bed mobility, transfers, walking in corridor, walking in room, and locomotion on unit. He required total dependence for bathing, extensive physical assistance for personal hygiene, limited physical assistance with toilet use and dressing, and only supervision with eating and locomotion off unit. Review of admission documentation revealed Resident #2 was his own responsible party and his son was listed as an emergency contact. Review of the medical record revealed Resident #2 was discharged on 04/23/19 following an incident where he was taken to jail by the local police overnight for a warrant unrelated to the facility stay. There was no documentation in the medical record regarding any specifics or details of the resident's discharge from the facility including transfer location, education on his medical care or physician follow up appointment or retrieving/obtaining current prescribed medications. Review of the law enforcement report	F 0609		

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F 0609	Continued From page 29	F 0609		

number 19-11044, dated 04/25/19 between 9:25 P.M. and 10:11 P.M., revealed Resident #2 was observed walking in the middle of the road. Police were dispatched to his location on the same road as the facility. When police arrived, they attempted to call the facility, but received no answer. They attempted again and spoke with a facility nurse who stated Resident #2 was "banned" from the facility. At that time, police contacted EMS because they felt Resident #2 was having a "diabetic emergency," even though there were no other notes to support this. When EMS arrived, they assessed him and took him to the emergency facility.

Review of EMS run report number 2019-00002586, dated 04/25/19, revealed Resident #2 had no injuries, and there were no complaints from the resident. The report indicated EMS met with patient and police officer. Patient stated he was trying to get back home and he was no longer welcomed in the nursing facility. Police officer reiterated the same thing when he asked the facility about Resident #2 entering the nursing facility. EMS spoke with the facility nurse and nurse stated, "he had been discharged by the facility and insurance would not pay for stay." At that time, Resident #2 was taken to the emergency room.

Review of the emergency room's history and physical, dated 04/26/19, revealed the

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F 0609	Continued From page 30	F 0609		

resident was going to receive care for encephalopathy (a brain disease that alters brain function or structure), which was noted most likely secondary to schizoaffective exacerbation and to receive care for acute onset chronic kidney disease.

Interview with Police Dispatcher #23 on 04/29/19 at 12:19 P.M. revealed the police were dispatched to the road the facility was located on by a concerned citizen on 04/25/19. They found Resident #2 in the middle of the road, so they picked him up. Resident #2 stated he was at the nursing facility until the day before (04/23/19), but he was told when he arrived back (on 04/25/19) that he had been discharged and not allowed to return. The police officer attempted to contact the facility, but no one answered. He finally got a hold of a nurse, and the nurse stated Resident #2 was banned from the facility. At that time, police called EMS and they took him to the emergency room for assessment.

Interview with Resident #2's family member on 04/29/19 at 1:44 P.M. revealed he was never told that Resident #2 was discharged from the nursing facility. Hospital Staff #19 called him and told him what happened, regarding the arrest and being taken to the emergency room. He stated he received a call from the facility on 04/26/19 and was told initially that Resident #2 could not be readmitted. But later that day, he received

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA 365206	(x2) multiple construction a. building _____ b. wing _____	(X3) DATE SURVEY COMPLETED 05/06/2019

name of provider or supplier	street address, city, state, zip code
UPTOWN WESTERVILLE HEALTHCARE	**140 OLD COUNTY LINE ROAD WESTERVILLE OH, 43081**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETIO N
F 0609	Continued From page 31 a call from Admissions Director #201 who stated Resident #2 could come back. He was also contacted on 04/29/19 by Admissions Director #201 and asked where Resident #2 was located. He did not tell them because he wasn't sure what they would have him sign. They stated again that he was welcome to come back to the facility. He stated he does not feel comfortable going to the facility to get Resident #2's personal belongings, so he was not sure what he was going to do. Interview with the Administrator on 04/29/19 at 11:35 A.M. and 12:09 P.M. confirmed Resident #2 did not receive adequate discharge information (list of medications, doctor's information, supply of medications, etc.) when he was discharged following his arrest on 04/23/19. He also confirmed that Resident #2's family was not notified by the facility about his discharge in a timely manner. He confirmed there was no bed hold notification, no discharge documentation or report given to the resident/family or to the arresting officers when he left. At the time of this interview, he did not know Resident #2 attempted to return to the facility and was banned from entering/being readmitted. He thought Resident #2 was still in jail at the time of this interview. On 05/02/19 at 3:15 P.M., the Administrator verified the facility has not reported an allegation of neglect to the State Agency.	F 0609		

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F 0609	Continued From page 32 2. Record review revealed Resident #3 was admitted to the facility on 01/26/18 with diagnoses including unspecified fracture of upper end of left tibia, calculus of kidney, rash and other nonspecific skin eruption, other chronic pain, constipation, alcohol abuse, polyneuropathy, other disorders of lung, unspecified fracture of sternum, other tear of unspecified meniscus in right knee, multiple fractures of ribs, personal injury in unspecified motor vehicle accident, muscle weakness, and difficulty walking. Review of the resident's cognition assessment, dated 02/20/19, revealed the resident was cognitively intact. Review of Resident #3's progress note revealed he had a planned surgery on 04/24/19. He was taken to the hospital by Social Services Assistant (SSA) #92 on 04/24/19. The facility received a call later that afternoon from the surgical center, stating that he would be admitted for observation, but everything was going well. According to the facility medical records for Resident #3, he was discharged from the facility on 04/24/19 with the explanation of, "not being able to provide the services needed following his surgery." The medical record was not specific as to what care could not be provide. The physician had not written any progress notes confirming the allegation. There was no indication Resident #3 was given written notification regarding his discharge. In	F 0609		

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F 0609	Continued From page 33 addition, there was no indication the state ombudsman's office was notified regarding this discharge. Interview with the Administrator on 04/29/19 at 11:35 A.M. and 12:09 P.M. revealed he could not find evidence Resident #3 was given notification he was not allowed to return to the facility. He stated the resident had an insurance that offered bed hold days and verified the resident should have received the notification about the daily rate and/or the option to refuse for their bed to be held. He stated he did not know they were not permitted to come back (or that they had been told this). The Administrator verified the facility did not provide any information regarding the resident's medical diagnosis, medications and care plan upon transfer to the hospital. The Administrator, during an interview on 05/02/19 at 3:17 P.M. verified the facility did not submit a self-reported incident to the State Agency to investigate the possibility of neglect. This deficiency substantiates Complaint Number OH00103991. This is an example of continued non-compliance from the survey dated 04/22/19.	F 0609		

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F 0622	Continued From page 34	F 0622		
F 0622 SS=D	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate.	F 0622	Resident #2 was admitted to the hospital on 4/25/19. Resident #2 was readmitted to facility on 5/9/19 and transferred to OSU Medical Center on 5/10/19. On 5/2/19 Administrator, LISW, DON, ADON and MDS nurse identified all residents with the potential to discharge to the community. All 14 of 14 resident's care plans were reviewed and revised as needed for safe discharge plan. On 4/29/19 at 5:30pm the LISW and ADON reviewed all 18 of 18 resident's discharged from the facility in the past 30 days to ensure the resident received a safe discharge plan. on 4/29/19 at 4:35pm the Regional Director of Clinical Services educated the Administrator on Resident Discharge, Transfer, and Bedhold Policy and Procedures. On 4/29/19 at 4:45pm the DON educated all 17 of 17 members of the interdisciplinary team on Resident Discharge, Transfer and Bedhold Policy and Procedures. On 4/29/19 between 5pm and 7pm Unit Managers educated all 27 of 27 licensed nurses on Resident Discharge, Transfer and Bedhold Policy and Procedures. On 5/1/19 inquiry received from River Vista regarding Resident #2's return to facility. Uptown Westerville agreed to Resident #2's re-admission to facility after a 14 day stay at River Vista Behavioral Hospital.	05/10/2019

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F 0622	Continued From page 35 (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-	F 0622	Administrator/Designee will audit all discharges x 4 weeks for compliance with Resident Discharge, Transfer and Bed-hold Policy and Procedures, then as determined by the QAA committee.	

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F 0622	Continued From page 36 (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This STANDARD is not met as evidenced by: Based on medical record review, staff interview, family interview, and facility policy review, the facility failed to provide appropriate justification for a resident discharge. This affected one (Resident #2) of three resident discharges reviewed. Findings Include: Record review revealed Resident #2 was	F 0622		

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F 0622	Continued From page 37 admitted to the facility on 01/08/17 with diagnoses including chronic kidney disease Stage IV, syncope and collapse, Type II diabetes, bipolar disorder, hyperlipidemia, major depressive disorder, osteoarthritis, dysuria, unspecified mood disorder, other chronic pain, peripheral vascular disease, Parkinson's disease, unspecified kidney failure, unspecified abdominal pain, weakness, altered mental status, cognitive communication deficit and difficulty walking. His Brief Interview for Mental Status (BIMS) score was 15, which indicated he was cognitively intact. The assessment was completed on 03/25/19. Review of Resident #2's medical records revealed he was discharged from the facility on 04/23/19; he was arrested at that time on charges unrelated to the facility. According to the Minimum Data Set 3.0 (MDS) assessment (dated 04/23/19), Resident #2 was discharged and not anticipated to return. In review of the electronic progress notes, there was no indication as to the reason for the discharge. Between 04/12/19 and 04/23/19, there were a total of 15 entries regarding verbal aggression and inappropriate behaviors by Resident #2 toward others (residents and staff). However, there was no documentation to support that Resident #2 was causing fear or distress to other residents.	F 0622		

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F 0622	Continued From page 38 Review of facility Self-Reported Incidents (SRI) revealed there were no incidents of peer to peer abuse with Resident #2 being the perpetrator. Interview with the acting Administrator on 04/29/19 at 11:35 A.M. and 12:09 P.M. revealed he thought Resident #2 was still in jail at the time of this interview. He stated he had no problem with Resident #2 returning to the facility and did not know that he had been discharged and not permitted to return. He stated the reason for his initial discharge was because he was arrested and taken to jail. He confirmed Resident #2 was not given a 30-day discharge notification. Interview with Social Services Assistant (SSA) #92 on 04/29/19 at 12:30 P.M. revealed Resident #2 was discharged from the facility because he called the police, they arrived at the facility, they "ran his name," and found that he had violated his restraining order over a family dispute; he was arrested. To her knowledge, Resident #2 never returned to the facility to ask if he could be readmitted. Per SSA #92, on 04/26/19 at approximately 2:30 P.M., a social worker from a medical facility/emergency room called and stated Resident #2 was in the emergency room and wanted to know "what was going on with him." She also wanted to know if he could go back to the facility. SSA #92 placed the hospital social worker on hold,	F 0622		

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F 0622	Continued From page 39 talked with the former administrator and was told, "We are not taking him back for any reason." SSA #92 had to relay this message to the hospital social worker. Interview with Resident #2's family member (son) on 04/29/19 at 1:44 P.M. revealed he was never told that Resident #2 was discharged from the nursing facility. Hospital Staff #19 called him and told him what happened (about the arrest and being taken to the emergency room). He stated he had not been given a reason for Resident #2's discharge. Review of the facility "Resident Discharge" policy and procedure (dated 01/01/16) indicated, it is the policy of this facility to provide the Resident's with a thorough and seamless discharge. It also stated, The social services designee shall follow the procedure outlined below regarding discharge: the facility will ensure a safe location to discharge the resident to; the facility will communicate with responsible parties/guardians about the decision to transfer, the facility will communicate with the location or individuals for the accepting transfer; the facility will provide all pertinent medical information; the facility will notify the physician and acquire the needed documentation for the transfer; and the facility will transfer the resident to new location. This deficiency substantiated Master	F 0622		

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F 0622	Continued From page 40 Complaint Number OH00104005	F 0622		

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F 0623	Continued From page 41	F 0623		
F 0623 SS=D	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)	F 0623	Resident #2 was admitted to the hospital on 4/25/19. Resident #2 was readmitted to facility on 5/9/19 and transferred to OSU Medical Center on 5/10/19. Resident #3 no longer resides in the facility. On 4/24/19 at 5pm Administrator, LISW, DON, ADON and MDS nurse identified all residents with the potential to discharge to the community. All 14 of 14 resident's care plans were reviewed and revised as needed for safe discharge plan. On 4/29/19 at 5:30pm the LISW and ADON reviewed all 18 of 18 resident's discharged from the facility in the past 30 days to ensure the resident received a safe discharge plan. on 4/29/19 at 4:35pm the Regional Director of Clinical Services educated the Administrator on Resident Discharge, Transfer, and Bedhold Policy and Procedures. On 4/29/19 at 4:45pm the DON educated all 17 of 17 members of the interdisciplinary team on Resident Discharge, Transfer and Bedhold Policy and Procedures. On 4/29/19 between 5pm and 7pm Unit Managers educated all 27 of 27 licensed nurses on Resident Discharge, Transfer and Bedhold Policy and Procedures. On 5/1/19 inquiry received from River Vista regarding Resident #2's return to facility.	05/10/2019

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F 0623	Continued From page 42 (1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection	F 0623	Uptown Westerville agreed to Resident #2's re-admission to facility after a 14 day stay at River Vista Behavioral Hospital. Administrator/Designee will audit all discharges x 4 weeks for compliance with Resident Discharge, Transfer and Bed-hold Policy and Procedures, then as determined by the QAA committee.	

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F 0623	Continued From page 43 and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This STANDARD is not met as evidenced by:	F 0623		

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F 0623	Continued From page 44 Based on medical record review, staff interview, and policy review, the facility failed to provide written notification of discharge to residents and the state ombudsman's office. This affected two (Resident #2 and Resident #3) of three residents reviewed for discharges. Findings Include: 1. Record review revealed Resident #2 was admitted to the facility on 01/08/17 with diagnoses including chronic kidney disease Stage IV, syncope and collapse, Type II diabetes, bipolar disorder, hyperlipidemia, major depressive disorder, osteoarthritis, dysuria, unspecified mood disorder, other chronic pain, peripheral vascular disease, Parkinson's disease, unspecified kidney failure, unspecified abdominal pain, weakness, altered mental status, cognitive communication deficit and difficulty walking. His Brief Interview for Mental Status (BIMS) score was 15, which indicated he was cognitively intact. The assessment was completed on 03/25/19. Review of Resident #2's medical records revealed he was discharged from the facility on 04/23/19 as he was taken to jail on an outstanding warrant. There was no indication that he was given written notification about his discharge from the facility. Also, there was no indication that	F 0623		

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F 0623	Continued From page 45 the state ombudsman's office was notified regarding this discharge. 2. Record review revealed Resident #3 was admitted to the facility on 01/26/18 with diagnoses including unspecified fracture of upper end of left tibia, calculus of kidney, rash and other nonspecific skin eruption, other chronic pain, constipation, alcohol abuse, polyneuropathy, other disorders of lung, unspecified fracture of sternum, other tear of unspecified meniscus in right knee, multiple fractures of ribs, personal injury in unspecified motor vehicle accident, muscle weakness, and difficulty walking. His BIMS score was 15, which indicated he was cognitively intact. This assessment was completed on 02/20/19. Review of Resident #3's medical records revealed he had a planned surgery on 04/24/19. He was taken to the hospital by Social Services Assistant (SSA) #92 on 04/24/19. The facility received a call later that afternoon from the surgical center, stating that he would be admitted for observation, but everything was going well. According to the facility medical records for Resident #3, he was discharged from the facility on 04/24/19 with the explanation of, "not being able to provide the services needed following his surgery." There was no indication that he was given written notification regarding his discharge. In addition, there was no indication the state ombudsman's office was notified	F 0623		

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F 0623	Continued From page 46 regarding this discharge. Interview with Administrator on 04/29/19 at 11:35 A.M. and 12:09 P.M. revealed he could not find evidence that either resident (Resident #2 or Resident #3) had received written notification of their discharge. The Administrator was asked on 04/29/19 at 11:15 A.M., 2:46 P.M., and 4:30 P.M. for evidence the state ombudsman's office was notified of these discharges, but this information was never provided. Review of the facility "Resident Discharge" policy and procedure (dated 01/01/16) revealed, "It is the policy of this facility to provide the Resident's with a thorough and seamless discharge." The social services designee shall follow the procedure outlined below regarding discharge: the facility will ensure a safe locations to discharge the resident to; the facility will communicate with responsible parties/guardians about the decision to transfer, the facility will communicate with the location or individuals for the accepting transfer; the facility will provide all pertinent medical information; the facility will notify the physician and acquire the needed documentation for the transfer; and the facility will transfer the resident to new location. This deficiency substantiated Master Complaint Number OH00104005 and Complaint Number OH00103991.	F 0623		

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F 0624	Continued From page 48	F 0624		
F 0624 SS=J	483.15(c)(7) Preparation for Safe/Orderly Transfer/Dschrg §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This STANDARD is not met as evidenced by: Based on review of the medical record, emergency medical report, law enforcement report, facility discharge policy, interviews with the medical director, staff, resident, family and local police and jail staff, the facility failed to ensure a resident discharge met the health and safety needs of one resident (Resident #2). This resulted in Immediate Jeopardy when Resident #2 was refused readmittance to the facility. This posed the likelihood of imminent danger or harm when Resident #2 was turned away from the facility after arriving by public transportation with no shelter to go to and no medications for treatment of multiple medical conditions. In addition, the facility failed to readmit one resident (Resident #3) following an overnight hospital admission for a surgical procedure. Resident #3 was admitted to an alternate facility. This affected two of three residents reviewed for proper discharge.	F 0624	Resident #2 was admitted to the hospital on 4/25/19. Resident #2 was readmitted to facility on 5/9/19 and transferred to OSU Medical Center on 5/10/19. Resident #3 no longer resides in the facility. On 4/24/19 at 5pm Administrator, LISW, DON, ADON and MDS nurse identified all residents with the potential to discharge to the community. All 14 of 14 resident's care plans were reviewed and revised as needed for safe discharge plan. On 04/29/19 at 5:00 P.M., the Administrator, Licensed Social Worker (LISW) #92, the DON, Assistant Director of Nursing (ADON) #123, and Minimum Data Set (MDS) Nurse #31 identified all residents with the potential to discharge to the community. All resident's care plans will be reviewed and revised as needed for safe discharge planning by 05/02/19. On 4/29/19 at 5:30pm the LISW and ADON reviewed all 18 of 18 resident's discharged from the facility in the past 30 days to ensure the resident received a safe discharge plan. On 4/29/19 at 4:35pm the Regional Director of Clinical Services educated the Administrator on Resident Discharge, Transfer, and Bedhold Policy and Procedures. On 4/29/19 at 4:45pm the DON educated all 17 of 17 members of the interdisciplinary team on Resident Discharge, Transfer and Bedhold	05/10/2019

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F 0624	Continued From page 49 On 04/29/19 at 4:26 P.M., the Administrator and Regional Director #42 were notified Immediate Jeopardy began on 04/23/19 when Resident #2 was removed from the facility by local police for an outstanding warrant after the resident had called the police to the facility because he was refused water. Resident #2 spent the night in jail and was refused readmittance to the facility following the overnight jail stay for an unrelated outstanding warrant. Resident #2 was turned away from the facility without any personal belongings or medical needs and was found by local police at 9:30 P.M. walking in the middle of a road near the facility. He was transported by emergency medical services (EMS) to the local hospital where he was admitted. The Immediate Jeopardy was removed on 05/02/19 when the facility implemented the following corrective actions: • Resident# 3 was transferred to a surgical center and admitted after a scheduled procedure on 4/24/19. Resident #3 was discharged from the surgical center to another nuring facility. • On 04/29/19 at 4:35 P.M., the Regional Director of Clinical Services #42 educated the Administrator on the facility's Resident Discharge Policy and Procedure and Discharge, Transfer and Bed Policy.	F 0624	Policy and Procedures. On 4/29/19 between 5pm and 7pm Unit Managers educated all 27 of 27 licensed nurses on Resident Discharge, Transfer and Bedhold Policy and Procedures. On 5/1/19 inquiry received from River Vista regarding Resident #2's return to facility. Uptown Westerville agreed to Resident #2's re-admission to facility after a 14 day stay at River Vista Behavioral Hospital. Administrator/Designee will audit all discharges x 4 weeks for compliance with Resident Discharge, Transfer and Bed-hold Policy and Procedures, then as determined by the QAA committee.	

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F 0624	Continued From page 50 • On 04/29/19 at 4:45 P.M., the Director of Nursing (DON) educated all 17 of 17 members of the interdisciplinary team on the facility's Resident Discharge Policy and Procedure and Discharge, Transfer and Bed Policy. • On 04/29/19 at 5:00 P.M., the Administrator, Licensed Social Worker (LISW) #92, the DON, Assistant Director of Nursing (ADON) #123, and Minimum Data Set (MDS) Nurse #31 identified all residents with the potential to discharge to the community. All resident's care plans will be reviewed and revised as needed for safe discharge planning by 05/02/19. • On 04/29/19 at 5:30 P.M., LISW #92 and ADON #123 reviewed all 18 of 18 residents discharged from the facility in the past 30 days to ensure the residents received a safe discharge by 05/02/19. • On 04/29/19 between 5:00 P.M. to 7:00 P.M., Unit Nurse Managers #123 and #143 educated all 27 of 27 licensed nurses on the facility's Resident Discharge Policy and Procedure and Discharge, Transfer and Bed Policy. • On 04/29/19, the Administrator/Designee will audit all discharges for four weeks for compliance with the Resident Discharge Policy and Procedure and Discharge, Transfer and	F 0624		

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F 0624	Continued From page 51 Bed Policy, then as determined by the Quality Assurance and Assessment Committee. • On 04/30/19, surveyors reviewed three additional closed resident records (Resident #1, Resident #5 and Resident #6) for residents who were discharged from the facility since 03/31/19. Reviews revealed safe discharges were completed for these residents. • On 05/01/19 between 10:30 A.M. and 11:00 A.M. interview with four Licensed Practical Nurses (LPNs) and one Registered Nurse (RN) verified they had received education from Unit Nurse Managers #123 and #143 on discharge planning and safe discharge of residents. Staff who were interviewed were knowledgeable of the facility's policies and procedures regarding discharge planning and safe discharge of residents. • On 05/02/19, the facility verified Resident #2 was admitted to the hospital on 4/25/19. Resident #2 is scheduled to be readmitted to the facility after a 14 day hospitalization at a behavioral hospital. Although the Immediate Jeopardy was removed, the facility remained out of compliance at a Severity Level 2 (No actual harm with potential for minimal harm that is not Immediate Jeopardy) as the facility is still in the process of	F 0624		

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F 0624	Continued From page 52 implementing their corrective action plan to ensure ongoing compliance. Findings include: Review of Resident #2's closed medical record revealed an admission date of 01/08/17 with diagnoses including chronic kidney disease Stage IV, syncope and collapse, type II diabetes, bipolar disorder, hyperlipidemia, major depressive disorder, osteoarthritis, unspecified mood disorder, chronic pain, peripheral vascular disease, Parkinson's disease, unspecified kidney failure, unspecified abdominal pain, weakness, cognitive communication deficit and difficulty walking. Review of physician orders revealed the following were some of the daily medications resident #2 required to treat medical diagnoses: • Depakote Delayed release 250 milligrams (mg) every six hours; seizure and manic episode treatment • Lipitor 10 mg once daily; treatment of hyperlipidemia • Amlodipine Besylate 5 mg daily; treatment of hypertension • Actos 15 mg daily; treatment of diabetes	F 0624		

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F 0624	Continued From page 53 • Invega Extended release 3 mg daily; treatment of mood disorder • Tamulosin HCl 0.4 mg; treatment of prostate hyperplasia • Oxybutynin Chloride 5 mg twice daily; treatment of painful urination/frequency • Trihexyphenidyl HCl 2 mg twice daily; treatment of Parkinson's Disease • Gabapentin 200 mg three times daily; treatment of nerve pain • Accu-check every morning to check blood sugars and notify physician if over 400 or under 40 milligrams per deciliter (mg/dl). Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment, dated 03/25/19, revealed Resident #2 was cognitively intact and required supervision and physical assistance for bed mobility, transfers, walking in corridor, walking in room, and locomotion on unit. He required total dependence for bathing, extensive physical assistance for personal hygiene, limited physical assistance with toilet use and dressing, and only supervision with eating and locomotion off unit. Review of admission documentation revealed Resident #2 was his own responsible party and his son was listed as an emergency	F 0624		

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F 0624	Continued From page 54 contact. Review of progress notes from 01/01/19 through 04/11/19 revealed Resident #2 had no documented behaviors. Review of progress notes from 04/12/19 to 04/23/19 revealed 15 entries related to verbal aggression from Resident #2 to staff and other residents. Resident #2 was taken to the emergency room on 04/18/19 to be assessed for his mental health. He returned to the facility the same day due to not meeting the threshold to be admitted to a psychiatric unit. The facility had contacted local law enforcement on 04/19/19 related to documentation that Resident #2 was aggressive and refused to go to the hospital for evaluation, but the police officers declined to transport the resident as he did not meet the criteria. Resident #2 remained at the facility at that time. Review of the facility's Self-Reported Incidents to the State Agency revealed no evidence of any incidents in the previous 30 days involving Resident #2. Review of a progress note dated 04/23/19 by Licensed Practical Nurse (LPN) #1 documented Resident #2 asked for ice water and when the aide on the hall went to give it to him, he called an aide a black slave (expletive), stating he did not want it from him or the (expletive) nurse. Resident #2 was noted to be in the hall yelling at staff and slamming his walker down. Resident #2 retreated to his room and	F 0624		

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F 0624	Continued From page 55 called the police to complain about his care. The local police arrived and spoke with staff and Resident #2. The police ran Resident #2's name through their system and located two outstanding warrants unrelated to the facility stay. Resident #2 was handcuffed and removed from the facility and taken to the local police station. On 04/23/19, an MDS assessment was started but not completed for Resident #2 regarding "Discharge, return not anticipated." Review of the medical record revealed Resident #2 was discharged on 04/23/19. There was no documentation in the medical record regarding any specifics or details of the resident's discharge from the facility including transfer location, education on his medical care or physician follow up appointment or retrieving/obtaining current prescribed medications. Review of the law enforcement report number 19-10814, dated 04/23/19, revealed law enforcement arrived at the nursing facility due to Resident #2 calling and stating the nursing staff would not provide him water. While in the facility, they determined Resident #2 had two outstanding warrants related to non-compliance with a protection order. He was placed in handcuffs and removed from the facility and taken to the county jail.	F 0624		

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F 0624	Continued From page 56 Review of the law enforcement report number 19-11044, dated 04/25/19 between 9:25 P.M. and 10:11 P.M., revealed Resident #2 was observed walking in the middle of the road. Police were dispatched to his location on the same road as the facility. When police arrived, they attempted to call the facility, but received no answer. They attempted again and spoke with a facility nurse who stated Resident #2 was "banned" from the facility. At that time, police contacted EMS because they felt Resident #2 was having a "diabetic emergency". There was no further documenttion regarding the diabetic emergency. When EMS arrived, they assessed him and took him to the emergency facility. Review of EMS run report number 2019-00002586, dated 04/25/19, revealed Resident #2 had no injuries, and there were no complaints from the resident. The report indicated EMS met with patient and police officer. Patient stated he was trying to get back home and he was no longer welcomed in the nursing facility. Police officer reiterated the same thing when he asked the facility about Resident #2 entering the nursing facility. EMS spoke with the facility nurse and nurse stated, "he had been discharged by the facility and insurance would not pay for stay." At that time, Resident #2 was taken to the emergency room.	F 0624		

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F 0624	Continued From page 57 Interview with Hospital Staff #19 on 04/29/19 at 11:52 A.M. revealed Resident #2 arrived at the medical facility on 04/25/19 at about 10:15 P.M. She stated he was not acting out of the ordinary or to the point that she felt he needed a psychiatric hold. Hospital Staff #19 helped him into an emergency room holding room, where Resident #2 remained the rest of the night. The next day (04/26/19) at approximately 2:30 P.M., Hospital Staff #19 contacted the nursing facility to find out if Resident #2 could return. She talked to Social Service Assistant (SSA) #92 and Former Director of Nursing (DON) #7 at the facility, who stated they spoke with Former Administrator #48, and they would not allow Resident #2 back into the facility. They told her that he was potentially violent, staff was afraid of him, and he would not be returning. At that time, Hospital Staff #19 worked to find a place for the resident to go. Resident #2 did not meet the criteria for a psychiatric hospital, so he was admitted to a hospital that had a psychiatrist who did floor rounds. Resident #2 was sent to this hospital on 04/26/19 and (to her knowledge), remained there to this day. Interview with Police Dispatcher #23 on 04/29/19 at 12:19 P.M. revealed the police were dispatched to the road the facility was located on by a concerned citizen on 04/25/19. They found Resident #2 in the	F 0624		

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F 0624	Continued From page 58	F 0624		

middle of the road, so they picked him up. Resident #2 stated he was at the nursing facility until the day before (04/23/19), but he was told when he arrived back (on 04/25/19) that he had been discharged and not allowed to return. The police officer attempted to contact the facility, but no one answered. He finally got a hold of a nurse, and the nurse stated Resident #2 was banned from the facility. At that time, police called EMS and they took him to the emergency room for assessment.

Interview with Sheriff Department Dispatcher #29 on 04/29/19 at 1:41 P.M. confirmed that Resident #2 was admitted to the jail on 04/24/19 and released on 04/25/19.

Interview with Resident #2's family member on 04/29/19 at 1:44 P.M. revealed he was never told that Resident #2 was discharged from the nursing facility. Hospital Staff #19 called him and told him what happened, regarding the arrest and being taken to the emergency room. He stated he received a call from the facility on 04/26/19 and was told initially that Resident #2 could not be readmitted. But later that day, he received a call from Admissions Director #201 who stated Resident #2 could come back. He was also contacted on 04/29/19 by Admissions Director #201 and asked where Resident #2 was located. He did not tell them because he wasn't sure what they would have him sign. They stated

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F 0624	Continued From page 59 again that he was welcome to come back to the facility. He stated he does not feel comfortable going to the facility to get Resident #2's personal belongings, so he was not sure what he was going to do. Interview with the Administrator on 04/29/19 at 11:35 A.M. and 12:09 P.M. confirmed Resident #2 did not receive adequate discharge information (list of medications, doctor's information, supply of medications, etc.) when he was discharged following his arrest on 04/23/19. He also confirmed that Resident #2's family was not notified by the facility about his discharge in a timely manner. He confirmed there was no bed hold notification, no discharge documentation or report given to the resident/family or to the arresting officers when he left. At the time of this interview, the Administrator did not know Resident #2 attempted to return to the facility and was banned from entering/being readmitted. The Administrator thought Resident #2 was still in jail at the time of this interview. Interview with SSA #92 on 04/29/19 at 12:30 P.M. revealed Resident #2 was discharged from the facility because he called the police, they arrived at the facility, they "ran his name," and found that he had violated his restraining order and then he was arrested. To her knowledge, he never returned to the facility to ask if he could be readmitted. SSA #92	F 0624		

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F 0624	Continued From page 60 stated on 04/26/19 at approximately 2:30 P.M., a social worker from a medical facility/emergency room called and stated Resident #2 was in the emergency room and wanted to know "what was going on with him." She also wanted to know if he could go back to the facility. SSA #92 stated she spoke with the Former Administrator who said, "We are not taking him back for any reason." SSA #92 had to relay this message to the hospital social worker. To SSA #92's knowledge, no one was notified of Resident #2's discharge, including his son. SSA #92 confirmed she did not set up home health or any other type of medical assistance when Resident #2 was discharged from the facility on 04/23/19. An attempt was made to interview Resident #2 on 04/29/19 at 1:51 P.M. and 4:07 P.M., and 04/30/19 at 10:25 A.M., but the attempts were unsuccessful. Attempts to interview LPN #100, the nurse who stated Resident #2 was banned from the facility, on 04/29/19 at 1:10 P.M. and 04/30/19 at 9:05 A.M. were unsuccessful. Telephone interview with the Former Administrator on 05/01/19 at 1:07 P.M. revealed she was not notified Resident 2's attempted return to the facility on 04/25/19. She stated that no staff tried to call her the night of 04/25/19. She said the interdisciplinary team discussed	F 0624		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETIO N
F 0624	Continued From page 61 Resident #2 with corporate consulting nurse (Current DON) in the meeting stated to not allow Resident #2 to return to the facility. Review of the facility's "Resident Discharge Policy and Procedure", dated 01/01/16, revealed it is the policy of the facility to provide the residents with a thorough and seamless discharge. The social services designee shall follow the procedure outlined below regarding discharge: the facility will ensure a safe locations to discharge the resident to, the facility will communicate with responsible parties/guardians about the decision to transfer, the facility will communicate with the location or individuals for the accepting transfer, the facility will provide all pertinent medical information, the facility will notify the physician and acquire the needed documentation for the transfer, and the facility will transfer the resident to a new location. 2. Record review revealed Resident #3 was admitted to the facility on 01/26/18 with diagnoses including unspecified fracture of upper end of left tibia, calculus of kidney, rash and other nonspecific skin eruption, other chronic pain, constipation, alcohol abuse, polyneuropathy, other disorders of lung, unspecified fracture of sternum, other tear of unspecified meniscus in right knee, multiple fractures of ribs, personal injury in unspecified motor	F 0624		

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365206	a. building _____ b. wing _____	05/06/2019

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F 0624	Continued From page 62 vehicle accident, muscle weakness, and difficulty walking. Review of the resident's cognition assessment, dated 02/20/19, revealed the resident was cognitively intact. Review of Resident #3's progress note revealed he had a planned surgery on 04/24/19. He was taken to the hospital by Social Services Assistant (SSA) #92 on 04/24/19. The facility received a call later that afternoon from the surgical center, stating that he would be admitted for observation, but everything was going well. According to the facility medical records for Resident #3, he was discharged from the facility on 04/24/19 with the explanation of, "not being able to provide the services needed following his surgery." There was no indication that he was given written notification regarding his discharge. In addition, there was no indication the state ombudsman's office was notified regarding this discharge. In review of all Resident #3's medical records, there was no preparation and/or documentation to support the resident and/or family were aware that Resident #3 would be discharged without the possibility of being able to return to the facility. There was no documentation to support the facility could not provide the care and services that Resident #3 required. Interview with the Administrator on	F 0624		

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F 0624	Continued From page 63 04/29/19 at 11:35 A.M. and 12:09 P.M. revealed he could not find evidence Resident #3 was given notification he was not allowed to return to the facility. He stated the resident had an insurance that offered bed hold days and verified the resident should have received the notification about the daily rate and/or the option to refuse for their bed to be held. He stated he did not know they were not permitted to come back (or that they had been told this). The Administrator verified the facility did not provide any information regarding the resident's medical diagnosis, medications and care plan upon transfer to the hospital. Interview with Social Services Assistant (SSA) #92 on 04/29/19 at 12:30 P.M. confirmed the facility was more than capable of providing care and services for Resident #3 to return after his surgery. She did not know why the resident was not permitted to return other than she took direction from former Administrator #48, who stated the resident was not permitted to return. Interview with Medical Director #304 on 04/30/19 at 6:13 P.M. confirmed the facility was able to accept Resident #3 back into the facility after his surgery. He confirmed they were able to provide adequate care and treatment for him. Review of facility "Emergency	F 0624		

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F 0624	Continued From page 64 Transfer/Discharge" policy, dated April 2017, revealed the facility attempts to meet the needs of residents within the facility, but in an acute situation when it is not in the best interest of the resident due to medical or safety reasons, an emergency transfer or discharge is implemented. Should it become necessary to implement an emergency transfer or a 30-day discharge to a hospital or other facility, the following procedures will be completed: notify the resident's physician, may be done after transfer in an emergency; notify the receiving facility the transfer is being made and provide relevant information, arrange transportation if not arranged by the receiving facility; prepare the resident for transfer, prepare transfer form, medication lists, code status, and other relevant documentation to send with the resident. Review of the facility's abuse prevention policy and procedure, dated 01/01/16, revealed the facility will follow state and federal guidelines on preventing abuse, neglect, mistreatment, exploitation and misappropriation of property. Neglect was defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, and mental illness. The training part of the procedure included to train all new employees on resident rights and how residents are to be treated and what to do if the employee suspects that the resident's rights have been violated and	F 0624		

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F 0624	Continued From page 65 when and how to report witnessed, alleged or suspected abuse. This deficiency substantiates Complaint Number OH00104005 and Complaint Number OH00103991.	F 0624		

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F 0625	Continued From page 66	F 0625		
F 0625 SS=D	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This STANDARD is not met as evidenced by:	F 0625	Resident #2 was admitted to the hospital on 4/25/19. Resident #2 was readmitted to facility on 5/9/19 and transferred to OSU Medical Center on 5/10/19. Resident #3 no longer resides in the facility. On 5/2/19 at 5pm Administrator, LISW, DON, ADON and MDS nurse identified all residents with the potential to discharge to the community. All 14 of 14 resident's care plans were reviewed and revised as needed for safe discharge plan. On 4/29/19 at 5:30pm the LISW and ADON reviewed all 18 of 18 resident's discharged from the facility in the past 30 days to ensure the resident received a safe discharge plan. on 4/29/19 at 4:35pm the Regional Director of Clinical Services educated the Administrator on Resident Discharge, Transfer, and Bedhold Policy and Procedures. On 4/29/19 at 4:45pm the DON educated all 17 of 17 members of the interdisciplinary team on Resident Discharge, Transfer and Bedhold Policy and Procedures. On 4/29/19 between 5pm and 7pm Unit Managers educated all 27 of 27 licensed nurses on Resident Discharge, Transfer and Bedhold Policy and Procedures. On 5/1/19 inquiry received from River Vista regarding Resident #2's return to facility.	05/10/2019

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F 0625	Continued From page 67 Based on medical record review, staff interview, and policy review, the facility will failed to provide bed hold notification to residents at the time of discharge. This affected two (Resident #2 and Resident #3) of three residents reviewed for discharges. Findings Include: 1. Record review revealed Resident #2 was admitted to the facility on 01/08/17 with diagnoses including chronic kidney disease Stage IV, syncope and collapse, Type II diabetes, bipolar disorder, hyperlipidemia, major depressive disorder, osteoarthritis, dysuria, unspecified mood disorder, other chronic pain, peripheral vascular disease, Parkinson's disease, unspecified kidney failure, unspecified abdominal pain, weakness, altered mental status, cognitive communication deficit and difficulty walking. His Brief Interview for Mental Status (BIMS) score was 15, which indicated he was cognitively intact. The assessment was completed on 03/25/19. Review of Resident #2's medical records revealed he was discharged from the facility on 04/23/19 as he was taken to jail on an outstanding warrant. There was no indication that he was given bed hold information at the time of discharge or shortly after.	F 0625	Uptown Westerville agreed to Resident #2's re-admission to facility after a 14 day stay at River Vista Behavioral Hospital. Administrator/Designee will audit all discharges x 4 weeks for compliance with Resident Discharge, Transfer and Bed-hold Policy and Procedures, then as determined by the QAA committee.	

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F 0625	Continued From page 68 2. Record review revealed Resident #3 was admitted to the facility on 01/26/18 with diagnoses including unspecified fracture of upper end of left tibia, calculus of kidney, rash and other nonspecific skin eruption, other chronic pain, constipation, alcohol abuse, polyneuropathy, other disorders of lung, unspecified fracture of sternum, other tear of unspecified meniscus in right knee, multiple fractures of ribs, personal injury in unspecified motor vehicle accident, muscle weakness, and difficulty walking. His BIMS score was 15, which indicated he was cognitively intact. This assessment was completed on 02/20/19. Review of Resident #3's medical records revealed he had a planned surgery on 04/24/19. He was taken to the hospital by Social Services Assistant (SSA) #92 on 04/24/19. The facility received a call later that afternoon from the surgical center, stating that he would be admitted for observation, but everything was going well. In review of all his medical records, there is no indication that he was given bed hold information at the time of discharge or shortly after. Interview with the Administrator on 04/29/19 at 11:35 A.M. and 12:09 P.M. revealed he could not find evidence that either resident (Resident #2 and #3) had received written bed hold notification at the time of their discharge. He stated neither one had insurance that offered bed hold	F 0625		

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F 0625	Continued From page 69 days but understood that both should have received the notification about the daily rate and/or the option to refuse for their bed to be held. Review of facility "Bed Hold Notification" policy (dated 01/01/16) revealed, "The administrator/designee will notify resident and the resident's responsible party in writing by certified mail, return receipt requested, in advance of any proposed transfer or discharge from this home. A copy of the notice will also be sent to the state department of health." This deficiency substantiated Master Complaint Number OH00104005 and Complaint Number OH00103991.	F 0625		

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F 0626	Continued From page 70	F 0626		
F 0626 SS=D	483.15(e)(1)(2) Permitting Residents to Return to Facility §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available	F 0626	Resident #2 was admitted to the hospital on 4/25/19. Resident #2 was readmitted to facility on 5/9/19 and transferred to OSU Medical Center on 5/10/19. Resident #3 no longer resides at the facility. On 5/2/19 Administrator, LISW, DON, ADON and MDS nurse identified all residents with the potential to discharge to the community. All 14 of 14 resident's care plans were reviewed and revised as needed for safe discharge plan. On 4/29/19 at 5:30pm the LISW and ADON reviewed all 18 of 18 resident's discharged from the facility in the past 30 days to ensure the resident received a safe discharge plan. on 4/29/19 at 4:35pm the Regional Director of Clinical Services educated the Administrator on Resident Discharge, Transfer, and Bedhold Policy and Procedures. On 4/29/19 at 4:45pm the DON educated all 17 of 17 members of the interdisciplinary team on Resident Discharge, Transfer and Bedhold Policy and Procedures. On 4/29/19 between 5pm and 7pm Unit Managers educated all 27 of 27 licensed nurses on Resident Discharge, Transfer and Bedhold Policy and Procedures. On 5/1/19 inquiry received from River Vista regarding Resident #2's return to facility. Uptown Westerville agreed to Resident #2's	05/10/2019

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F 0626	Continued From page 71 in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This STANDARD is not met as evidenced by: Based on medical record review, staff interview, medical director interview, and facility policy review, the facility failed to permit residents to return to the facility after they were hospitalized or on therapeutic leave. This affected two (Resident #2 and Resident #3) of three resident discharges reviewed. Findings Include: 1. Record review revealed Resident #2 was admitted to the facility on 01/08/17 with diagnoses including chronic kidney disease Stage IV, syncope and collapse, Type II diabetes, bipolar disorder, hyperlipidemia, major depressive disorder, osteoarthritis, dysuria, unspecified mood disorder, other chronic pain, peripheral vascular disease, Parkinson's disease, unspecified kidney failure, unspecified abdominal pain, weakness, altered mental status, cognitive communication deficit and difficulty walking. His Brief Interview for Mental Status (BIMS) score was 15, which indicated he was cognitively intact. The assessment was completed on 03/25/19.	F 0626	re-admission to facility after a 14 day stay at River Vista Behavioral Hospital. Administrator/Designee will audit all discharges x 4 weeks for compliance with Resident Discharge, Transfer and Bed-hold Policy and Procedures, then as determined by the QAA committee.	

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F 0626	Continued From page 72 Review of Resident #2's medical records revealed he was discharged from the facility on 04/23/19 as he was taken to jail on an outstanding warrant. There was no preparation and/or documentation to support the resident and/or family were aware that he would be discharged without the possibility of being able to return to the facility. There was no documentation to support the facility could not provide the care and services that Resident #2 required. 2. Record review revealed Resident #3 was admitted to the facility on 01/26/18 with diagnoses including unspecified fracture of upper end of left tibia, calculus of kidney, rash and other nonspecific skin eruption, other chronic pain, constipation, alcohol abuse, polyneuropathy, other disorders of lung, unspecified fracture of sternum, other tear of unspecified meniscus in right knee, multiple fractures of ribs, personal injury in unspecified motor vehicle accident, muscle weakness, and difficulty walking. His BIMS score was 15, which indicated he was cognitively intact. This assessment was completed on 02/20/19. Review of Resident #3's medical records revealed he had a planned surgery on 04/24/19. He was taken to the hospital by Social Services Assistant (SSA) #92 on 04/24/19. The facility received a call later that afternoon from the surgical center, stating that he would be admitted for	F 0626		

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F 0626	Continued From page 73 observation, but everything was going well. In review of all his medical records, there was no preparation and/or documentation to support the resident and/or family were aware that Resident #3 would be discharged without the possibility of being able to return to the facility. There was no documentation to support the facility could not provide the care and services that Resident #3 required. Interview with the Administrator on 04/29/19 at 11:35 A.M. and 12:09 P.M. revealed he could not find evidence that either resident (Resident #2 and Resident #3) had received written bed hold notification at the time of their discharge. He stated neither one had insurance that offered bed hold days but understood that both should have received the notification about the daily rate and/or the option to refuse for their bed to be held. He confirmed that both residents were welcome to come back and that they were able to provide the services needed for their care. He stated he did not know they were not permitted to come back (or that they had been told this). Interview with Social Services Assistant (SSA) #92 on 04/29/19 at 12:30 P.M. confirmed the facility was more than capable of providing care and services for Resident #3 to return after his surgery. She did not know why either resident was not permitted to return other than she took	F 0626		

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F 0626	Continued From page 74 direction from former Administrator #48, who stated they were not permitted to return. Interview with Medical Director #304 on 04/30/19 at 6:13 P.M. confirmed the facility was able to accept Resident #3 back into the facility after his surgery. He confirmed they were able to provide adequate care and treatment for him. Review of facility "Emergency Transfer/Discharge" Policy (dated April 2017) revealed the facility attempts to meet the needs of residents within the facility, but in an acute situation when it is not in the best interest of the resident due to medical or safety reasons, an emergency transfer or discharge is implemented. Should it become necessary to implement an emergency transfer or 30 day discharge to a hospital or other facility, the following procedures will be completed: notify the resident's physician, may be done after transfer in an emergency; notify the receiving facility the transfer is being made and provide relevant information, arrange transportation if not arranged by the receiving facility; prepare the resident for transfer, prepare transfer form, medication lists, code status, and other relevant documentation to send with the resident; notify the responsible party/family member as soon as possible, if the discharge is an acute emergency they may be notified after he transfer;	F 0626		

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F 0626	Continued From page 75 provide care and treatment as needed until care is transferred to the emergency squad or the agency providing the transportation; document the information including what occurred, assessments, care, and treatment provided, resident status and response, notifications and other related information; complete the documentation routinely associated with a discharge; depending on the specific situation, the external marketer or social services will follow-up with the resident/responsible party or hospital/agency regarding the status of the resident until the resident returns to the facility, or it is determined the resident will not be returning; and if there is a question whether the facility is able to meet the medical, physical, emotional or safety needs of the resident, the administrator with input from the DON will make the final determination whether the facility will readmit the resident. This deficiency substantiated Master Complaint Number OH00104005 and Complaint Number OH00103991.	F 0626		

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F 0690	Continued From page 76	F 0690		
F 0690 SS=D	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is	F 0690	On 5/2/19 the nurse manager ensured Resident #121 received an anchoring device. On 5/2/19 the Nurse Manager assessed Resident #121 for any s/sx of discomfort or skin impairment and no adverse findings were identified. Resident #121 care plan was reviewed by the Nurse Manager. On 5/2/19 DON or Designee assessed all Resident's with a Foley Catheter for discomfort, skin impairment and ensured all resident's had an anchoring device in place. No negative findings were identified. Resident care plans were reviewed and revised as necessary. On 5/2/19 DON educated STNA #35 and STNA #750 on the Catheter Care Policy which includes securing the tubing with a leg strap or anchoring device. The DON or designee will educate facility STNA and licensed nursing staff on the Catheter Care Policy by 5/10/19 to ensure the safety, comfort and well-being of resident's with an indwelling catheter in place. The DON or designee will conduct random audits of 3-5 resident's with an indwelling catheter to ensure a leg strap or anchoring device is in place 3 x weekly x 4 weeks, then as determined by the QAA committee.	05/10/2019

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F 0690	Continued From page 77 incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This STANDARD is not met as evidenced by: Based on observation, review of facility catheter care policy, record review and staff interviews, the facility failed to provide one of three sampled residents (Resident #121) with an anchor device for his urinary catheter. The facility identified four residents with urinary catheters. The facility census was 111. Findings include: Review of Resident #121's medical record revealed an admission to the facility on 04/27/17. Diagnoses included hospice services for end of life care, stroke and Parkinson disease. The record identified Resident #121 was receiving comfort care only. The record identified Resident #121 had a urinary catheter for urinary retention. Review of the facility's written plan of care, updated through 07/21/19 for Resident #121, revealed interventions included to secure the catheter with a securement device. Observation on 05/02/19 at 9:12 A.M. revealed Resident #121 was receiving catheter care from State Tested Nursing Assistants (STNAs) #35 and #750. The	F 0690		

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F 0690	Continued From page 78 observation revealed Resident #121 did not have an anchoring device to hold the catheter in place. The observation identified the weight of the catheter tubing and attached bag was pulling Resident #121's penis to the side. Interviews with STNAs #35 and #750 on 05/02/19 at 9:21 A.M. confirmed Resident #121 did not have a securing device located on his catheter. Review of the facility's policy titled "Catheter Care Policy and Procedure," dated 12/01/18, identified the procedure included to ensure tubing is secured with a leg strap and/or anchoring device. This was an incidental finding during the course of the complaint investigation.	F 0690		

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F 0760	Continued From page 79	F 0760		
F 0760 SS=G	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This STANDARD is not met as evidenced by: Based on medical record review, staff interview and review of the Medscape Guidelines 2019, the facility failed to ensure one resident (Resident #4) was free of a significant medication error. This resulted in actual harm when Resident #4 received an oral anticoagulant (blood thinning) medication (Coumadin), after the physician had ordered the medication be held due to an elevated International Normalized Ratio (INR) level (used to monitor therapeutic levels of blood clotting). Resident #4 required hospitalization for a diagnosis of supratherapeutic INR (excessively thin blood). This affected one of three residents reviewed for a significant medication error. The facility identified 17 residents receiving anticoagulant medication. The facility census was 111. Findings include: Review of Resident #4's medical record revealed the resident was admitted to the facility on 6/27/18. Diagnoses included atrial fibrillation, history of deep vein thrombosis and peripheral vascular	F 0760	Resident #4 no longer resides in the facility and currently resides in another SNF. On 4/17/19 at 23:04 Resident #4 PT/INR results were reported to Med One with no new orders. On 4/18/19 at 00:52 Resident #4 was sent to the ER per order for evaluation and treatment. On 5/3/19 DON and Nurse manager assessed all Residents on coumadin therapy for any change in condition and no adverse findings were identified. On 5/09/19 DON and nurse manager began medical record review audit to identify any documented change in condition and all residents current coumadin therapy regimen was reviewed with the Resident's physician or CNP by 5/10/19. No further adverse outcomes were identified related to coumadin therapy. On 5/3/19 DON and Nurse Managers re-educated licensed nursing staff on Physician Notification Policy(which includes critical lab value notification), Change in Condition Policy, 10 Rights of Medication Administration and S/Sx and risks associated with a non-therapeutic PT/INR and factors that may effect INR levels. On 5/3/19 the DON and Nurse Managers re-educated STNA staff on S/Sx of abnormal bleeding and Change in Condition Policy. Don or designee will audit the medical record of resident's receiving coumadin 2x weekly x 4 weeks to ensure MAR is accurate per physician order, laboratory draws are accurate and therapeutic, Lab values are addressed with	05/10/2019

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F 0760	Continued From page 80 disease. Review of the comprehensive assessment, dated 04/02/19, revealed Resident #4 was alert, oriented and able to voice all needs. The assessment identified Resident #4 had two venous/arterial ulcers. Review of the April 2019 physician orders identified Resident #4 was receiving Coumadin daily for atrial fibrillation. Review of Resident #4's progress note, dated 04/15/19 at 7:07 P.M., revealed the laboratory results received for the resident's PT (prothrombin time) was at a level of 52.2 seconds; (normal range 9.5-11.8 seconds) and an INR at 4.7 with normal range (2.0-3.0 standard anti-coagulant). This test is used to monitor blood thinning medications. The progress note identified the physician was notified and ordered the Coumadin held and recheck PT/INR tomorrow (04/16/19). The laboratory findings identified the INR levels as critical. Review of a progress note, dated 04/15/19 at 10:53 P.M., revealed the Certified Nurse Practitioner (CNP) ordered Levaquin (antibiotic medication) for a urinary tract infection (UTI). The CNP additionally ordered INR testing every other day, for a week. The progress note, dated 04/16/19 at 5:26	F 0760	the physician/CNP , identify change in condition with appropriate physician/CNP notification and ensure Resident is negative for any S/Sx of abnormal bleeding. Need for further auditing will be determined by the QAA committee.	

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F 0760	Continued From page 81	F 0760		

P.M., revealed the results of the PT/INR were received, and the on-call physician was notified. The PT was 55.5 and INR was 5.0 and the physician ordered a hold on the Coumadin medication. The notes additionally identified to retest tomorrow. The laboratory findings identified the INR levels were critical.

The progress note, dated 04/17/19 at 5:20 A.M., revealed at 4:00 A.M., there was a significant amount of bright red blood saturating the entire left lower extremity dressing and sheet. There was no evidence the physician was notified.

Review of the Medication Administration record (MAR) for April 2019 revealed Resident #4's Coumadin was held as ordered, on 04/15/19 and 04/16/19. However, the resident was administered Coumadin on 04/17/19 at 5:00 P.M., despite the physician order to hold the medication.

The progress note, dated 04/17/19 at 11:04 P.M., identified there were critical lab values called to the physician. The lab valuers were noted as PT at 49.1 and INR at 4.4.

Review of the progress note dated 04/18/19 at 12:52 A.M. revealed Resident #4 became unresponsive, had very pale skin and would not respond to verbal or physical stimuli. Resident #4 was helped

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F 0760	Continued From page 82 into bed and a code blue (emergency) was called. Emergency Medical Services; 911 was called, and a physician order was received to send Resident #4 to the emergency room for evaluation. Review of the hospital history and physical, dated 04/18/19 at 4:11 A.M., revealed Resident #4 was admitted to the hospital with diagnoses of supratherapeutic INR and syncope (passing out), as well as acute onset chronic renal failure. Resident #4's INR was 4.46 upon admission to the hospital. Interview on 05/02/19 at 2:20 P.M. with the Director of Nursing (DON) confirmed Resident #4's MAR identified she was administered Coumadin on 04/17/19. The DON confirmed she should not have been given the medication as the medication was on hold per physician order. Review of medication information titled "Medscape Guidelines 2019" revealed Coumadin was an anticoagulant and used as treatment of deep vein thrombosis, myocardial infarction, pulmonary embolism, rheumatic heart disease with heart valve damage, prosthetic heart valves and chronic atrial fibrillation. Under black box warning it indicated Coumadin can cause major or fatal bleeding; bleeding is more likely to occur during the starting period and with a higher dose (resulting in a higher INR). Risk factors for bleeding	F 0760		

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F 0760	Continued From page 83 include high intensity of anticoagulation (INR greater that 4), and age sixty-five years or older. Regular monitoring of INR should be performed on all treated patients; those at high risk for bleeding may benefit from more frequent INR monitoring, careful dose adjustment to desired INR and a shorter duration of therapy is recommended. This deficiency is an example of continued non-compliance from the survey dated 04/1/19.	F 0760		

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F 0773	Continued From page 84	F 0773		
F 0773 SS=D	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This STANDARD is not met as evidenced by: Based on record review, review of facility policy and staff interview, the facility failed to timely notify the physician of one resident's (resident #4) critical laboratory results. This affected one of three residents reviewed for critical laboratory results. The facility census was 111. Findings include: Review of Resident #4's medical record revealed the resident was admitted to the facility on 06/27/18. Diagnoses included atrial fibrillation, history of deep vein thrombosis and peripheral vascular disease. Review of the comprehensive	F 0773	Resident #4 no longer resides in the facility and currently resides in another SNF. On 4/17/19 at 23:04 Resident #4 PT/INR results were reported to Med One with order to continue to hold and report to CNP in the morning. On 4/18/19 at 00:52 Resident #4 was sent to the ER per order for evaluation and treatment. On 5/3/19 DON and Nurse manager assessed all Residents on coumadin therapy for any change in condition and no adverse findings were identified. On 5/09/19 DON and nurse manager began medical record review audit to identify any documented change in condition and all residents current coumadin therapy regimen was reviewed with the Resident's physician or CNP by 5/10/19. No further adverse outcomes were identified related to coumadin therapy. On 5/3/19 DON and Nurse Managers re-educated licensed nursing staff on Physician Notification Policy(which includes critical lab value notification), Change in Condition Policy, 10 Rights of Medication Administration and S/Sx and risks associated with a non-therapeutic PT/INR and factors that may effect INR levels. On 5/3/19 the DON and Nurse Managers re-educated STNA staff on S/Sx of abnormal bleeding and Change in Condition Policy. Don or designee will audit the medical record of resident's receiving coumadin 2x weekly x 4 weeks to ensure MAR is accurate per	05/10/2019

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F 0773	Continued From page 85 assessment, dated 04/02/19, revealed Resident #4 was alert, oriented and able to voice all her needs. Review of the April 2019 physician orders identified Resident #4 was receiving Coumadin (an anticoagulant) daily for atrial fibrillation. Review of the laboratory report, dated 04/15/19, revealed the resident was tested for Prothrombin (PT) and International Normalized Ratio (INR) levels (used to monitor therapeutic levels of blood clotting) and was collected on 04/15/19 at 6:28 A.M. The results identified a critical INR level of 4.7 (normal range was 2.0-3.0 standard anti-coagulant). The laboratory test identified the result was reported to the facility on 04/15/19 at 11:37 A.M. The progress notes revealed no notification to the physician until 04/15/19 at 7:07 P.M. Review of the laboratory report, dated 04/16/19 with a collection time at 8:13 A.M., identified a reported critical INR was identified with notification to the facility at 1:59 P.M. The laboratory findings identified the INR levels were critical. The progress note revealed the physician was not notified until 04/16/19 at 5:26 P.M. The physician issued an order to hold the Coumadin medication and to retest tomorrow, (04/17/19). Review of the laboratory report, dated	F 0773	physician order, laboratory draws are accurate and therapeutic, Lab values are addressed with the physician/CNP , identify change in condition with appropriate physician/CNP notification and ensure Resident is negative for any S/Sx of abnormal bleeding. Need for further auditing will be determined by the QAA committee.	

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F 0773	Continued From page 86 04/17/19 with a collection time at 9:20 A.M., identified a critical INR was identified and reported to the facility on 04/17/19 at 12:37 P.M. The progress note revealed the physician was not notified until 04/17/19 at 11:04 P.M. The results were noted as an INR of 4.4. Interview on 05/02/19 at 3:40 P.M. with the Director of Nursing (DON) confirmed the facility nursing staff were notified by the laboratory company of any critical results, by phone. The DON confirmed the facility staff should immediately call the physician and wait no longer than one hour for a response. The DON confirmed the facility did not do this for Resident #4's critical INR results on 04/15/19, 04/16/19 and 04/17/19. Review of the facility's physician notification policy and procedure, dated 12/01/18, identified critical labs must be reported to the physician immediately. The physician should respond within one hour. This is an incidental finding discovered during the complaint investigation.	F 0773		

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F 0835	Continued From page 87	F 0835		
F 0835 SS=F	483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This STANDARD is not met as evidenced by: Based on review of employee personnel records, review of the Bureau of Criminal Identification and Investigation (BCI & I) log, review of the Ohio Attorney General's website, review of the abuse policy and procedures and staff interviews, the facility failed to be administered in a manner to use its resources effectively and efficiently to maintain the highest well being of each resident by failing to follow their policies to obtain and submit employee fingerprints to the BCI & I. The facility identified 36 employees hired since 12/21/18 and not had finger prints submitted to the BCI & I (Registered Nurse (RN) #11, #13, #20, #22, #24 and #35; Licensed Practical Nurse (LPN) #3, #7, #8, #10, #12, #14, #15, #16, #17, #19, #21, #25, #26, #27 and #32; State Tested Nursing Assistants (STNA) #1, #4, #29, #30, #31, #34 and #36; Kitchen staff (#2 and #6); Activities staff (Activities #9); Receptionist #18; Housekeeping staff (Housekeeping #5 and #28); Licensed Social Worker (LSW) #23; and Admissions Staff #33). This had the	F 0835	Finger prints were submitted to the BCI & I for Registered Nurse (RN) #11, #13, #20, #22, #24 and #35; Licensed Practical Nurse (LPN) #3, #7, #8, #10, #12, #14, #15, #16, #17, #19, #21, #25, #26, #27 and #32; State Tested Nursing Assistants (STNA) #1, #4, #29, #30, #31, #34 and #36; Kitchen staff (#2 and #6); Activities staff (Activities #9); Receptionist #18; Housekeeping staff (Housekeeping #5 and #28); Licensed Social Worker (LSW) #23; and Admissions Staff #33) by 5/3/2019. On 5/3/2019 the Administrator/designee reviewed resident concern forms and resident council minutes for the past 30 days to ensure all concerns were addressed and no residents had adverse outcomes related to the fingerprinting. No adverse findings were identified. On 5/2/19 DON/Designee re-educated all staff on the abuse policy and were unable to return to work until the education was received. On 5/16/19 the Background Check Policy was revised by the VP of Clinical Services. Regional Director of Clinical Services educated the Administrator, HR Director, and Department Managers on the revised Background Check Policy on 5/17/19. Administrator/Designee will audit all new employee files for evidence of compliance with the Background Check Policy and finger printing prior to the employee beginning work x 4weeks, then as determined by the QAA	05/17/2019

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F 0835	Continued From page 88 potential to affect all 111 residents residing in the facility. Finding include: Review of the BCI&I log and interview with the facility Administrator on 05/01/19 at 9:17 A.M. revealed a new corporation took ownership of the facility on 12/21/18. The Administrator verified 36 employees have been hired since that time who are still employed at the facility. The Administrator verified none of these 36 employees: (RN) #11, #13, #20, #22, #24 and #35; Licensed Practical Nurse (LPN) #3, #7, #8, #10, #12, #14, #15, #16, #17, #19, #21, #25, #26, #27 and #32; State Tested Nursing Assistants (STNA) #1, #4, #29, #30, #31, #34 and #36; Kitchen staff (#2 and #6); Activities staff (Activities #9); Receptionist #18; Housekeeping staff (Housekeeping #5 and #28); Licensed Social Worker (LSW) #23; and Admissions Staff #33) have had a set of finger prints completed and submitted to BCI&I for a criminal records check to be completed. The Administrator verified the facility was utilizing a company identified as "Ohio Background Check, INC" that completes a background check but does not utilize fingerprints. The facility was unable to provide any evidence of what this company was utilizing to complete the "background checks". Review of the Ohio Attorneys General web-site (ohioattorneygeneral.gov) revealed	F 0835	committee.	

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F 0835	Continued From page 89 BCI&I compares fingerprints received against database of criminal fingerprints to determine if there is a criminal record. The site identified all fingerprints must be submitted to BCI&I electronically through a webcheck or a scan card. Review of the facility "abuse, abuse prevention" policy and procedure dated 01/01/16 identified in the section for screening staff included; "criminal background checks are conducted per this facility's policy and procedure. Potential employees or volunteers with negative findings of background checks will not be hired". Review of the "employee background checks" policy dated 10/2018 identified "all employees will conduct a background check through the BCI&I prior to starting work." This policy also incorrectly identified staff would be able to start work and work for 90 days until the results of the check are returned. This deficiency was cited as an incidental finding to Master Complaint Number OH00104005 and Complaint Number OH00103991.	F 0835		